STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155561	A. BUILDING _____ B. WING _____	R-C 10/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN HOME & REHABILITATIVE CENTER	231 N JACKSON ST OAKLAND CITY, IN 47660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaint IN00131239 completed on 7/2/13.

This visit was done in conjunction with the PSR to the Investigation of Complaint IN00133590 and Complaint IN00134089 completed on 8/29/13, and the Investigation of Complaint IN00136186 and Complaint IN00137106.

Complaint IN00131239 - Corrected.

Survey dates:
September 30 and October 1, 2013

Facility number: 000327
Provider number: 155561
AIM number: 100273920

Survey team:
Anne Marie Crays RN

Census bed type:
SNF/NF: 89
Total: 89

Census payor type:
Medicare: 8
Medicaid: 58
Other: 23
Total: 89

Sample: 7

Good Samaritan Home and Rehabilitation Center was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2 in regard to the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155561	A. BUILDING _____ B. WING _____	R-C 10/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN HOME & REHABILITATIVE CENTER	231 N JACKSON ST OAKLAND CITY, IN 47660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 PSR to the Investigation of Complaint IN00131239. Quality review completed on October 2, 2013, by Jodi Meyer, RN	{F 000}		